



Seattle Childrens MRN:	Seattle Children's Account #	SCH log-in performed by:	Date:
<b>FAILURE TO COMPLETE MAY DELAY RESULTS</b>			
Patient's Last Name	First	Middle	Birth date (required)
Outside Patient Number	Outside Specimen Number	Send Report To:	
Ordering Provider	Address:		
Provider Phone Number	DIAGNOSIS / ICD-9:	Phone/Fax:	

**IMPORTANT INFORMATION REGARDING BILLING AND MEDICAL NECESSITY ON BACK**

<b>FAX ADDITIONAL RESULTS TO:</b>	<b>HEALTHCARE PROFESSIONAL TO CALL FOR INFO/ABNORMAL RESULTS:</b>
NAME (please print): _____	NAME (please print): _____
FAX #: _____	PHONE #: _____

**SPECIMEN INFORMATION**

Date collected: \_\_\_\_/\_\_\_\_/\_\_\_\_ Specimen Type:  EDTA  Extracted DNA  Cultured Amniocytes  Other:  
 Time collected: \_\_\_\_\_  ACD  Cultured Skin Fibroblasts  Cultured CVS \_\_\_\_\_

**PATIENT / FAMILY HISTORY**

**REASON FOR STUDY:**  Diagnostic  Carrier Testing (affected family member)  Prenatal testing (Consent form required)  
 Carrier Testing (no family history) LMP: \_\_\_\_\_ EDC: \_\_\_\_\_

**CLINICAL FINDINGS:** \_\_\_\_\_

**ETHNICITY** (check all that apply):  African American  Ashkenazi Jewish  Asian  European Caucasian  
 Hispanic  Native Alaskan  Native American Indian  Pacific Islander  Other: \_\_\_\_\_

**HISTORY (or attach pedigree):** Indicate results of previous genetics studies, dates and case numbers, and where the studies were performed.

**DNA ANALYSIS**

<p><b>DIABETES TESTING:</b></p> <input type="checkbox"/> MODY Panel (HNF1A, GCK, HNF4A) <input type="checkbox"/> Neonatal Diabetes Panel (KCNJ11, INS, ABCC8, GCK) <input type="checkbox"/> <b>Individual</b> Diabetes Gene Sequencing (please indicate gene): <input type="checkbox"/> ABCC8 <input type="checkbox"/> GCK <input type="checkbox"/> HNF1A <input type="checkbox"/> HNF4A <input type="checkbox"/> INS <input type="checkbox"/> KCNJ11 <input type="checkbox"/> <b>Known</b> Diabetes Mutation please specify: _____ <p>DNA BANK <input type="checkbox"/> DNA Banking <u>ONLY</u> (Separate Consent Form Required)</p> <p>FRAGX DNA <input type="checkbox"/> Fragile X (A &amp; E)          FRAGX DNA <input type="checkbox"/> Fragile X E ONLY          FA <input type="checkbox"/> Friedreich's ataxia (GAA expansion only)</p> <p>GALT DNA <input type="checkbox"/> Galactosemia (8 mutations)          GALT DNA 1 <input type="checkbox"/> Galactosemia, known mutation analysis          Please specify: _____</p> <p>GAUCHE DNA <input type="checkbox"/> Gaucher Disease (11 mutations)          GAUCHESEQ <input type="checkbox"/> Gaucher Disease Sequencing Analysis          GAUCHE KNWN <input type="checkbox"/> Gaucher Disease, Known Mutation Analysis          Please specify: _____</p> <p>LCHAD SEQ <input type="checkbox"/> LCHAD/TFP (HADHA) Sequencing Analysis          LCHAD SEQ <input type="checkbox"/> LCHAD/TFP (HADHB) Sequencing Analysis          LCHAD SEQ <input type="checkbox"/> LCHAD/TFP (HADHA + HADHB) Sequencing  <input type="checkbox"/> Simultaneous  <input type="checkbox"/> Sequential (please indicate order) _____</p> <p>LCHAD KNWN <input type="checkbox"/> LCHAD/TFP Known Mutation Analysis          Please specify: HADHA _____          HADHB _____</p> <p>MCAD <input type="checkbox"/> MCAD Mutation Panel (2 mutations)          MCAD SEQ <input type="checkbox"/> MCAD Sequencing Analysis          MCAD KNOWN <input type="checkbox"/> MCAD, Known Mutation Analysis          Please specify: _____</p> <p>MATCONTAM <input type="checkbox"/> Maternal Cell Contamination</p>	<p>MD DNA <input type="checkbox"/> Duchenne/Becker Muscular Dystrophy          POLG1 SEQ <input type="checkbox"/> Polymerase Gamma 1 Sequencing Analysis          POLG1 KN <input type="checkbox"/> Polymerase Gamma 1 Known Mutation Analysis          Please specify: _____</p> <p>POLG2 SEQ <input type="checkbox"/> Polymerase Gamma 2 Sequencing Analysis          POLG2 KN <input type="checkbox"/> Polymerase Gamma 2 Known Mutation Analysis          Please specify: _____</p> <p>POMPE SEQ <input type="checkbox"/> Pompe Sequencing Analysis          POMPE KNWN <input type="checkbox"/> Pompe Known Mutation Analysis          Please specify: _____</p> <p>PWS-AS <input type="checkbox"/> DNA Methylation study (check one or both) <input type="checkbox"/> Angelman <input type="checkbox"/> Prader-Willi          AGXT SEQ <input type="checkbox"/> Primary Hyperoxaluria Type 1 Sequencing Analysis          AGXT KNOWN <input type="checkbox"/> Primary Hyperoxaluria Type 1, Known Mutation Analysis          Please specify: _____</p> <p>ALDH7A1 <input type="checkbox"/> Pyridoxine-Dependent Seizures Sequencing Analysis          ALDH7A1 KN <input type="checkbox"/> Pyridoxine-Dependent Seizures, Known Mutation Analysis          Please specify: _____</p> <p>MECP2 SEQ <input type="checkbox"/> Rett Syndrome (MECP2 gene) DNA Sequencing          MECP2 KNOWN <input type="checkbox"/> Rett Syndrome (MECP2 gene), Known Mutation Analysis          Please specify: _____</p> <p>SMA <input type="checkbox"/> Spinal Muscular Atrophy (Diagnostic)          SMACARRIER <input type="checkbox"/> Spinal Muscular Atrophy Carrier Testing          TYR DNA <input type="checkbox"/> Tyrosinemia type 1 (7 mutations)          VLCAD SEQ <input type="checkbox"/> VLCAD DNA Sequencing Analysis          VLCAD KNWN <input type="checkbox"/> VLCAD, Known Mutation Analysis          Please specify: _____</p> <p>ATP7B SEQ <input type="checkbox"/> Wilson Disease Sequencing Analysis          ATP7B KKNWN <input type="checkbox"/> Wilson Disease, Known Mutation Analysis          Please specify: _____</p> <p>OTHER: _____</p>
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**IMPORTANT INFORMATION REGARDING BILLING AND MEDICAL NECESSITY:**

ALL SAMPLES WILL BE BILLED TO THE REFERRING INSTITUTION UNLESS COMPLETE BILLING AND DIAGNOSIS INFORMATION IS PROVIDED ON THIS FORM. CONTACT SEATTLE CHILDREN'S LABORATORY CLIENT SERVICES FOR ADDITIONAL ASSISTANCE. (206) 987-2617

**PHYSICIAN NOTIFICATION:** Only tests that you believe are appropriate for patient care should be ordered. Medicare/Medicaid will pay only for tests that are medically necessary for the diagnosis and treatment of the patient, rather than for screening purposes.

**ALL INFORMATION MUST BE COMPLETE**

- BILL TO:**  Referring Institution (Preferred) - Provide billing address if different from report address  
 (Institutional billing will be done for all patients with Medicare except for established Seattle Children's patients.)
- Insurance (attach front and back copy of card)  DSHS (Only Alaska, Idaho, Montana & Washington accepted)
- Patient - please provide credit card information below or enclose a check

Guarantor		Relationship to patient	
Address			
Address (if different from patient's)			
Phone Number		Employer	
Insurance Company/Medical Coverage			
Claims Address			
Policy Number		Group Number	
Subscriber		Subscriber DOB	
Primary Care Physician		Phone Number	
Name On Credit Card		Amount Of Payment	
Card Number		Card Type	Expiration

**DNA ANALYSIS SAMPLE INFORMATION:**

PLEASE REFER TO [www.seattlechildrens.org/geneticslab](http://www.seattlechildrens.org/geneticslab) FOR COMPLETE TEST INFORMATION, SPECIMEN REQUIREMENTS, ADDITIONAL FORMS & SPECIAL INSTRUCTIONS

**DNA TESTS**

Blood Specimens: 3-5 mL ACD or EDTA whole blood. Keep specimens at room temperature. Transport specimens to laboratory immediately  
 \*\*\*\*Sodium Heparin (green top) tubes are NOT acceptable for DNA tests.\*\*\*

Also accepted: Extracted DNA - minimum 10 ug, ship room temperature  
 Cultured cells - 2 T25 flasks, ship room temperature. Prenatal samples MUST be approved by genetic counselor or lab director and consent form is required.

**DNA BANK**

5-10 mL ACD or EDTA whole blood. Keep at room temperature. Transport specimens to laboratory immediately. DNA Bank consent is required

**CONTACT INFORMATION:**

If you have questions or wish to consult the staff about the testing or specimen requirements, please call:

Molecular Genetics Lab	(206) 987-3872
Sihoun Hahn, MD PhD	(206) 987-7610

**SHIP OVERNIGHT AT ROOM TEMPERATURE TO:**



**Laboratory A-6901**  
**4800 Sand Point Way NE**  
**Seattle, WA 98105**  
**(206) 987-2102**

\*\*\*PEDIGREE DIAGRAM (Only one needed per family)\*\*\*